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Eugen Bleuler's Concept of Schizophrenia and Its Relevance to Present-Day Psychiatry

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Key Words
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Abstract
This paper links the historical perspective with the actual debate on the concept of schizophrenia. By this, two aims shall be accomplished. First, to prove that Eugen Bleuler's (1857–1939) concept of 'schizophrenia' in its central parts was a clear step forward, as compared to previous approaches, especially the notion of 'dementia praecox', proposed and favored by French authors like Bénédict Augustin Morel (1809–1873) and, in Germany, by Emil Kraepelin (1856–1926). Bleuler considerably reduced the epistemological presuppositions of Kraepelin's nosological model and coined the term 'group of schizophrenias', which was markedly broader and, as for prognosis, much less pessimistic. The second aim of this paper is to argue in favor of a continuous reflection upon psychiatry's historical and epistemological basis which is regarded not just as 'l'art pour l'art', but as an indispensable component of psychiatry, clinically and scientifically.

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Psychiatry Is in Need of the Historical and Epistemological Perspectives

As a medical discipline, psychiatry, in some respects, finds itself in a special situation. It is much closer interrelated with developments in society and politics than other medical fields. And psychiatry always dealt with, not to say consisted of controversial theories, regarding such central topics as models of illness, diagnosis and

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therapy [1]. For example, no other medical area experienced such a profound criticism towards its basic assumptions as did psychiatry when confronted with the positions of anti-psychiatry. In addition, psychiatry and psychotherapy are indispensably and strongly depending on theoretical presuppositions, which typically reach far beyond the medical field in a narrow sense, e.g. the issues of mind-body relationship, the dichotomy between subjective and objective methods and intersubjectivity. Finally, ethical considerations are always of crucial importance for any clinical decision, especially given the tension between paternalistic approaches with their strong emphasis on the competence of the medical specialist on the one side and the notion of personal autonomy of any person, be he or she mentally healthy or not, on the other side. All these topics play a significant role for any possible model of mental illness.

These special features of psychiatry have always been present in our field. Even a brief look at its history since about 1800 reveals a highly heterogeneous and controversial collection of models. They are, of course, closely coupled with the historical conditions under which they were formulated. Therefore, the need for the historical perspective becomes obvious in order to profoundly comprehend these complex developments. Just some prominent examples of psychiatric models since the time of enlightenment shall be mentioned without going into any detail: Romantic psychiatry (Johann Christian August Heinroth[1]), unitarian psychosis (Albert Zeller, Wilhelm Griesinger), natural disease entities (Emil Kraepelin), the group of schizophrenias (Eugen Bleuler), the etiological relevance of unconscious mental events (Sigmund Freud), anthropological psychiatry (Ludwig Binswanger), the 'somatosis postulate' (Kurt Schneider), the approach of structural dynamics (Werner Janzarik), anti-psychiatry (Thomas Szasz), system theory (Paul Watzlawick), cognitive behavioral approach (Aaron Beck), neurotransmission (Arvid Carlsson), the concept of denosologization (Herman van Praag) and, finally, the different facets of molecular psychiatry in recent years.

To cut that short, four approaches to understand or define mental disorders can be identified as underlying the, for some, embarrassing multitude of theories in psychiatry:

(1) Mental disorder as neurobiological dysfunction. In this view, the cause and 'real' character, not to say the 'essence' of mental illness is a biological dysfunction of the CNS, whereas psychopathological phenomena are seen as mere epiphenomena of the underlying somatic process.

(2) Mental disorder as biographically understandable individual reaction or development. This approach focuses on understanding psychologically, by means of empathy and interpretation, the process that, for example, leads from constraining life events to increased numbers of critical situations and, finally, to a severe depressive episode with somatic symptoms. This, however, does not imply that any case of mental disorder will be fully explainable. But the focus here is clearly on the understanding of biographical developments and much less on the neurobiological level.

(3) Mental disorder as socially understandable individual reaction or development. Psychopathological phenomena in this view have to be seen in a much broader than the individual context. The relevant groups of people the patient lives or works with, social and economic circumstances, even society in general have to be taken into account, e.g. when a given mental disorder is understood as a consequence of long unemployment or, more generally, of bad living conditions. Of course, the individual perspective is still important here. The emphasis, however, is on factors reaching far beyond the single person.

(4) Mental disorder as descriptive abnormality. This is the way chosen by modern operationalized diagnostic manuals, ICD-10 [2] and DSM-IV [3]. They represent a nominalistic and pragmatic diagnostic approach that does not claim to make statements about etiology[2], pathogenesis or therapy of any given mental disorder, but to provide the clinician with reliable diagnostic concepts. This idea had already been supported by Kurt Schneider (1887–1967), the Heidelberg psychopathologist who suggested 'first rank symptoms' for the diagnosis of schizophrenia. These 'FRS' were intended to be reliable diagnostic criteria with no direct link to etiological hypotheses.

In addition to these more general reasons why the historical perspective is important for psychiatric theories, I want to emphasize *two remarkable parallels* regarding the field of psychiatry in the decades around the years 1900 and 2000:

[1] Names in brackets are examples of important contributors, not references.

[2] This principle, however, is not fully respected throughout the diagnostic manuals. For example, the F0 and F1 groups in ICD-10 carry etiological hypotheses even in their titles (F0: Organic, including symptomatic, mental disorders; F1: Mental and behavioral disorders due to psychoactive substance use) [2].

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- Both periods witnessed a strong tendency to naturalize psychiatry in general and psychopathological phenomena in particular. However, I cannot address the complex issue of degeneration theory here, although that is a highly relevant topic in the history of psychiatry. A considerable number of thorough research activities addressed this field in the last decades, especially regarding classical authors like Emil Kraepelin, Richard von Krafft-Ebing or Eugen Bleuler [4–6]. Nevertheless, continuing interdisciplinary investigations are still needed. The crucial point in our present context is that at the end of the 19th and the end of the 20th century psychiatry focused on (neuro-)biological approaches to or even explanations of pathological mental phenomena and, at least in relevant parts, understood itself as an empirical neuroscientific field.
- Both periods included engaged debates on the best way to define or clarify psychiatry's identity as a clinical and research discipline. There is, however, a certain difference here. At the end of the 19th century, psychiatry, first of all, had to establish itself as an academic field. With some self-confidence, it developed or applied new empirical approaches in close neighborhood to the natural sciences, especially to biology. As opposed to this, psychiatry today is in a much more defensive position. Its future identity may seem questionable if the huge overlapping with fields as biochemistry, neurophysiology, brain imaging, genetics and neuropsychology is taken into account. Some would prefer to replace the term psychiatry by, for example, clinical neuroscience or behavioral neurobiology.

To fully comprehend these parallels and discrepancies between Bleuler's time and today and – even more important – to make this knowledge useful for our ongoing debate on the identity of psychiatry, the methods and results of research into the history of psychiatric ideas, 'conceptual history' in German Berrios' phrase [7], are strongly needed.

Indeed, there is reason to be moderately optimistic in this respect. In the last decades, the interest in the history of psychiatry rose considerably, as did the number of scientific publications related to that field. This is also the case for research on Eugen Bleuler [8–13].

Eugen Bleuler and the Group of Schizophrenias

Eugen Bleuler lived from 1857 to 1939. He received his residential training in psychiatry from 1881 to 1886. From 1886 to 1898, he was the medical director of the mental asylum in Rheinau in the most northern part of the canton of Zurich. From there, he returned to the University of Zurich and was appointed to the chair of psychiatry at the psychiatric university hospital, the 'Burghölzli'. This position he occupied from 1898 to 1927, nearly 30 years. He was elected head of the medical faculty from 1902 to 1904 and rector of the University of Zurich from 1924 to 1926.

It was on April 24th, 1908, when Bleuler for the first time used the term schizophrenia or group of schizophrenias in public. This happened on the occasion of a psychiatric meeting in Berlin at the Charité hospital where Bleuler gave a lecture titled 'Prognosis of Dementia praecox (Group of Schizophrenias)'. To give an impression of the type of arguments he brought forward I quote the most important passage of his talk:

'… I wish to emphasize again that the kraepelinian dementia praecox neither necessarily is a dementia, nor does it necessarily require praecocitas. Therefore, and because it is not possible to create proper adjectives or nouns from the term dementia praecox, I allow myself here to suggest the word *schizophrenia* to characterize the kraepelinian notion. I do believe that the interruption or dissociation of mental functions is an outstanding symptom of the whole group, and I will give reasons for this elsewhere.' [14, translated by P.H.].

And indeed, 3 years later, in 1911, Eugen Bleuler published his chapter on 'Dementia praecox or the group of schizophrenias' in Gustav Aschaffenburg's widely recognized handbook of psychiatry [15]. It is a very long chapter of 420 pages. Here, Bleuler gave a comprehensive and detailed overview of his new concept, its origins and clinical consequences. That very publication is the reason why most commemorations of the origins of 'schizophrenia' took place in 2011 and not in 2008.

As for the theoretical foundations of Bleuler's thinking on schizophrenia, 3 authors have to be mentioned: Johann Friedrich Herbart (1776–1841), Emil Kraepelin (1856–1926) and Sigmund Freud (1856–1939).

Johann Friedrich Herbart was an influential philosopher, educator and psychologist in the first half of the 19th century. In the present context, his understanding of psychology as a science is important. In German speaking countries[3], Herbart was one of the main proponents of association theory, a basic epistemological concept of

[3] The intellectual tradition of association theory is, of course, much broader. The epistemology of the Scottish philosopher David Hume (1711–1776), for example, had specific variants of sensualism and association theory as core components.

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mental events in general. It suggested that human mental life consists of multiple combinations ('associations') of single mental acts, especially sensory inputs. More complex cognitive functions in this view are nothing but results of this continuous process of combining single, not to say atomistic basic units of mental life. Considering Bleuler's statement cited above, where he emphasizes the notion of disturbed or interrupted mental functions in the pathogenesis of schizophrenic psychosis, it is obvious, that Herbart's association psychology became and stayed a relevant point of reference for him.

In addition, following Wilhelm Wundt (1832–1920) and others, academic psychology of Bleuler's time strongly favored an experimental approach which, in many cases, included the quantification of associative processes. His own general support of association psychology provided Bleuler with the opportunity to link quantitative and qualitative, especially hermeneutic, methods in psychiatric research. Carl Gustav Jung (1875–1961), being a close collaborator of Bleuler at the Burghölzli from 1900 to 1910, applied the technique of association experiments in his clinical studies on schizophrenia. Both Bleuler and Freud regarded this as a highly promising research field[4].

Emil Kraepelin not only introduced the dichotomy of schizophrenic and manic-depressive psychoses, but also for the whole of his long psychiatric career made a strong claim for the existence and scientific detectability of natural disease entities in psychiatry. These entities, in his view, exist fully independently from the researcher or therapist. They are, as he liked to put it, 'given by nature' [16]. Since Kraepelin well recognized that the chance to identify these entities by pathological anatomy or etiological research in psychiatry of his time was rather low, he favored a clinical approach – in this case following Karl Ludwig Kahlbaum (1828–1899) – that mainly relied on the long-term course of illness. The prognosis of psychotic disorders became, as will be mentioned shortly, a point of disagreement between him and Bleuler.

Sigmund Freud, founder of psychoanalysis, experienced some obstacles in communicating his concept to contemporary academic psychiatry which was generally skeptical, if not overtly disapproving. There is one major exception to this rule, Eugen Bleuler. Bleuler was the only influential academic psychiatrist of his time who not only entered the scientific debate on psychoanalysis, but also actively introduced psychoanalytic concepts into the diagnostic and therapeutic procedures of severely disturbed psychotic patients at the Burghölzli hospital. As Küchenhoff [17] has shown in detail, Bleuler, though generally supporting psychoanalysis as significant part of psychiatry, always maintained a critical attitude, especially with regard to the founding (1910) and inner structure of the International Psychoanalytical Association.

Summing up these theoretical issues, I refer to Scharfetter's [9, 18] convincing differentiation between four cornerstones of Bleuler's concept of schizophrenia:

- Bleuler accepted Kraepelin's clinical descriptions to a great extent when it comes to the differential diagnosis of schizophrenic psychoses, bipolar psychoses and other mental disorders. This may sound astonishing since Bleuler and Kraepelin are often described as strong antipodes. In some respects, they indeed are antipodes, but in other important respects they are definitely not. Clearly Bleuler differed from Kraepelin by insisting that schizophrenic patients do not necessarily have a poor prognosis. Furthermore, he disagreed with the strong notion of scientifically detectable natural disease entities in psychiatry which he, at least, rendered premature, especially when it comes to dementia praecox or schizophrenia. But – and that is more important here – Bleuler did support the clinical and descriptive approach by which Kraepelin had illustrated in detail the clinical characteristics of 'dementia praecox' as compared with other mental disorders.
- Bleuler also agreed with Kraepelin's epistemologically strong hypothesis of a (neuro-)biological causation of psychotic illness. This, nota bene, was not addressing any single psychopathological phenomenon, but the postulated 'underlying disease process', to use the kraepelinian term. Such a point of view did not rule out the clinical and scientific significance of psychological and social factors – especially not in Bleuler's thinking, but it insisted on a brain dysfunction, albeit poorly described and understood, as a decisive component of the etiology of schizophrenia both in Kraepelin and Bleuler.
- Following Herbart's concept of association psychology, Bleuler regarded the opposite of association, i.e. dissociation of mental functions, to be a core feature of the pathogenesis of schizophrenia. Therefore, Bleuler's 'basic symptoms', which will be illustrated below, strongly referred to this dichotomy between associative and dissociative qualities of human mental life.
- As already mentioned, Eugen Bleuler was the only influential academic psychiatrist of his time to openly

[4] The relationships between Bleuler, Freud and Jung were complicated and led to growing areas of scientific and personal disagreement. This issue cannot be discussed here in any detail.

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and constantly support and apply psychoanalytical concepts in diagnosing and treating psychotic patients. There are interesting and detailed descriptions on how Bleuler and his colleagues[5] applied psychoanalytic techniques in interviewing patients and – the via regia of psychoanalysis according to Freud – in interpreting dreams [19].

Turning to the clinical perspective of Bleuler's concept, we first have to address two dichotomies he introduced, basic and accessory symptoms on the one hand and primary and secondary symptoms on the other hand.

In Bleuler's understanding, basic symptoms of schizophrenia like disorders of association, ambivalence or a certain type of autistic behavior (not to be mixed up with the modern notion of autism) are necessarily present in any schizophrenic person, no matter what clinical type or course of illness he or she might represent. As opposed to that, accessory symptoms may or may not be present in schizophrenia, they are no mandatory prerequisite for this diagnosis. It is remarkable that Bleuler regarded clinically prominent psychotic features like hearing voices, paranoid ideas or psychomotor abnormalities as being accessory, although they often dominate the clinical picture.

The second dichotomy between primary and secondary symptoms introduces the etiological perspective. For Bleuler, primary symptoms directly, i.e. causally, result from the postulated underlying neurobiological dysfunction, whereas secondary symptoms are seen as psychologically understandable reactions of the mentally ill person to his or her psychotic experiences, e.g. to deeply disturbing primary symptoms as loosening of associations or other formal thought disorders.

The point, at which Bleuler most significantly departed from Kraepelin's position, was the long-term course of schizophrenia. In Bleuler's view, based upon many years of personal experience with chronically psychotic patients in the mental hospital in Rheinau and also later at the Burghölzli in Zurich, the group of schizophrenias may display a highly heterogeneous course of illness from a once-in-a-lifetime psychotic episode with full recovery over recurrent episodes with different degrees of (in modern terms) negative symptoms until, the worst case, a steady deterioration as seen in many cases of hebephrenic schizophrenia. That is why Bleuler – in the passage quoted above – insisted that schizophrenia does not necessarily begin early in life (is not necessarily 'praecox') nor does it always lead to a serious, if not catastrophic mental deterioration (not to 'dementia' in a kraepelinian sense).

Finally, as mentioned in the context of his theoretical approach, Bleuler included hermeneutic elements, not all of them classical psychoanalytical techniques, of course, in the diagnosis and therapy of his schizophrenic patients in a very pragmatic manner. One aspect is crucial in order to understand his pragmatism. It was not Bleuler's intention to implement psychoanalysis per se, but as one, albeit an important tool supporting his general attitude towards psychotic patients. They should be treated with respect and as much closeness as possible. His son, Manfred Bleuler (1986), put it this way:

'One of Bleuler's main aims in choosing and following his career was to arrive at an understanding of the schizophrenic symptoms as expressions of an inner psychodynamic life.… He studied the schizophrenic's inner life essentially in the same way as we study the inner life of neurotics, of healthy men, and of ourselves' [20].

So Bleuler, very much unlike Kraepelin, saw no contradiction between the basic assumption of an underlying neurobiological dysfunction in schizophrenia and the systematic application of hermeneutic and psychoanalytical methods to what his patients experienced and told him about. Given that basic attitude, it was only consequent for Bleuler to regard the neurobiological etiology of schizophrenic psychoses as a strong and scientifically important hypothesis, which, however, did not exclude the option of psychogenesis. Bleuler therefore also rejected the idea of a clear dividing line between schizophrenic (or, in general, psychotic) states on the one hand and neuroses on the other hand, at least regarding the relevance of psychological, i.e. hermeneutically approachable, features.

When it comes to the interaction of neurobiological and psychological factors, Bleuler outlined a framework that, in part, is strongly suggestive of the modern concept of vulnerability. The following quotation illustrates these aspects by which Bleuler further developed the kraepelinian perspective of 'dementia praecox' into a direction still relevant today:

'But we have to add that the presupposition of an organic disease process is not absolutely necessary. It is possible that the whole symptomatology is of psychological origin and that it might develop on the background of minor quantitative deviations from normality.… If there is a minor or barely progressive brain alteration, only a severe psychological trauma will be able to bring on the manifest illness. But the faster the disease process is progressing and the more pronounced the continuous alter-

[5] Some of these were Carl Gustav Jung, Karl Abraham, Franz Riklin, Alphonse Maeder, Ludwig Binswanger, Max Eitingon.

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ation is, the smaller the causes will have to be that trigger increasingly prominent disturbances. At the end, even daily hassles will further destabilize the fragile mental balance. Therefore, in most cases both etiological factors contribute to the emergence of psychotic syndromes.' [15, pp. 373, 374, translated by P.H.].

Eugen Bleuler and Schizophrenia Research Today

Going through the actual literature on schizophrenia, many different points of view and a considerable number of controversies will turn up. Some regard schizophrenia as a brain disease which still has to be diagnosed mainly by psychopathological means, but they expect the latter to lose importance as soon as reliable and valid biological markers of the illness will have been found [21]. For others, the clinical phenomenon that we call schizophrenia does exist on the symptom and syndrome levels, but definitely not as a separate or 'natural', i.e. neurobiological, disease entity. Even more, this epistemologically strong notion of a disease entity called schizophrenia is not only rendered unnecessary in this perspective, but is seen as misleading. Authors voting for that position suggest to 'deconstruct' the term psychosis. 'Deconstruction' is a central idea to many postmodern philosophical concepts. They decline and, consequently, deconstruct classical 'grand theories' like the notions of an autonomous subject, free will or apriorical presuppositions of generating knowledge (as, for example, Kant had suggested). Applied to psychiatry, this would mean to criticize and, finally, abolish such overarching notions that – in these authors' view – have not been proven scientifically fruitful, e.g. *schizophrenia* or *mental illness as a group of disease entities*. Consequently, a redirection of the research focus towards clinical symptoms and syndromes is postulated, no matter whether that research rests upon the neuroscientific, psychopathological or social sciences perspective [22]. Again, others do accept the existence of a broad spectrum of psychotic disorders named 'group of schizophrenias', but emphasize that there is no clear boundary between psychotic illness and healthy mental life. Studies have indeed repeatedly shown that subjective experiences we usually call psychotic can appear in the general population in persons who neither seek psychiatric advice nor report any substantial impairment in their everyday life [23]. Finally, there is a broad debate on whether and how 'schizophrenia' should be implemented in the upcoming new versions of the operationalized diagnostic manuals, i.e. ICD-11 and DSM-V [24, 25].

If we link these scientific controversies about the existence and usefulness of the concept of schizophrenia with the political debate in several countries, whether that very concept, mainly due to its undeniable and strong stigmatizing properties, should eventually be banned and fully replaced by some other expression, one issue is evident: 'Schizophrenia', named and disseminated by Eugen Bleuler 100 years ago, on the one hand became a major psychiatric concept all over the world in a markedly short period of time and, on the other hand, has always been the object, not to say target of controversies.

There are, indeed, 'lessons to learn' when reflecting on Bleuler's concept today. The following topics in my view are the most relevant ones for present-day psychiatry:

- Eugen Bleuler insisted on the complexity of the clinical picture and especially the long-term course of what he proposed to call 'group of schizophrenias'. This complexity includes and intertwines etiology, pathogenesis and clinical symptomatology:
  'On the basis of the same brain dysfunction one patient may fully recover, another one – given slightly different mental preconditions or missing stimulation or strong psychological traumatization – may become severely mentally disturbed. We cannot deduce different courses of illness or different groups of illnesses, neither from psychological predispositions or experiences nor from any supposed disease process.' [15, p. 375, translated by P.H.].
  This attitude, in Bleuler's case based on an experience with schizophrenic people lasting for decades, should also prevent us nowadays from accepting simplifying or one-sided descriptions or explanations of schizophrenia too readily.
- Although Eugen Bleuler in certain respects indeed was a naturalistic psychiatrist[6], he opposed any overtly reductionistic naturalism that declared psycho(patho) logical phenomena including the notion of subjectivity as scientifically irrelevant *epi*phenomena of neurobiological processes. 'Naturalism without reductionism': that catchword comes close to Bleuler's lifelong attitude towards psychiatric research – and the issue of naturalism is at the center of the actual debate on psychiatry, too [28, 29].
- As for deconstructing psychosis, the situation is similarly complicated: Bleuler in a way deconstructed

[6] His self-confident, but peculiar opinions on the mind-body-relationship ran him into some trouble epistemologically, especially with regard to the grossly speculative naturalism and vitalism in his later work [26, 27].

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Kraepelin's strong notion of dementia praecox and replaced it by a broader, more open and epistemologically 'weaker' concept, his 'group of schizophrenias'. Bleuler was skeptical about scientifically overstated notions (like dementia praecox), but did not suggest a radical deconstruction of psychosis, leaving behind only a group of symptoms. In other words: He did not deny the necessity of a valid and clinically practicable concept of psychotic illness.

- Bleuler accepted (and stressed) the heterogeneity of schizophrenia, and therefore consequently supported quite different clinical and scientific methods to approach this field. In modern terms, one could say that Bleuler, strongly arguing for a neurobiological underpinning of schizophrenia, promoted and applied methods with a descriptive, hermeneutic and social science background in diagnosing and treating his schizophrenic patients. Regarding the present day status of therapeutic options in schizophrenia, which is, of course, far beyond what Bleuler could have imagined, his multidimensional concept looks more future oriented and – as we could say – personalized than Emil Kraepelin's much more restricted notion of dementia praecox [30, 31]. To be more specific, there are especially two bleulerian positions that pointed beyond Kraepelin's perspective and may well be fruitful for the present-day debate: his skeptical, but not fully disapproving view of 'natural disease entities', and his acceptance of hermeneutic methods in psychiatric research. Today, these aspects turn up when possible targets of research are evaluated. Are these targets diseases, syndromes or symptoms? And they play a significant role when it comes to the epistemological and clinical status of operationalized psychiatric diagnoses as in ICD-10 [2]/DSM-IV [3] and their suggested supplementation by qualitative elements (e.g. in operationalized psychodynamic diagnoses [32]).
- Bleuler emphasized disturbances of association as core features in schizophrenia, phenomena, we would probably call cognitive symptoms. However, it was always clear for him that these cognitive domains cannot be separated categorically from the affective dimension. This may, at least in part, be a result of his energetic application of psychoanalytical ideas and methods that systematically take the affective components of any experience and behavior into account. Again, this is a very modern topic. Cognition alone will not be a sufficient issue in research and therapy for schizophrenic patients unless it is linked to affectivity and other relevant psychopathological dimensions.

Three theses shall summarize the main ideas of this paper:

(1) Bleuler strongly emphasized disturbances of association as basic symptoms of schizophrenia. By doing so, he, on the one hand, continued the tradition of association psychology, especially in the sense of Herbart in the early 19th century. On the other hand, and that is more relevant here, he also gave a strong impulse towards the development of a cognition-oriented research into schizophrenia that took place in the 20th century.

(2) Bleuler – like most of his contemporary colleagues in academic psychiatry – postulated a strong neurobiological component in the etiology of schizophrenia. But he was and remained highly skeptical against the notion of natural disease entities that, in contrast, had always been at the center of Kraepelin's nosological concept. Given the present-day debate on the status of schizophrenia, this bleulerian position, too, seems to be a modern one, but also a demanding one since it dares avoiding reassuring, but speculative nosological assumptions.

(3) Given the enormous complexity of schizophrenia on the clinical and research levels, Bleuler's multidimensional approach may be regarded useful nowadays because of its open-minded clinical attitude. Bleuler combined differentiated psychopathological methods with an explicit long-term perspective on the course of illness. There is a tension, albeit not an explicit contradiction in Bleuler's broad and, at times, highly speculative naturalism on the one hand and his pragmatic multidimensional approach to clinical work on the other hand. Although he may have underestimated the philosophical pitfalls of naturalism, he advocated – in modern terms – the combination of neurobiology, psychopathology (including hermeneutics) and social sciences. And this seems to be a reasonable guideline also for present-day psychiatry.

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